MEDICARE ADVANTAGE REFORM AND BURDEN REDUCTION

One of the principal goals of Medicare Advantage (MA) reform is to provide Medicare beneficiaries with the kinds of coverage choices reliably available to every beneficiary in the country in the Federal Employees Health Benefits (FEHB) Program. CMS expects that these reforms will result in the participation of additional health plans in the MA program that will provide more beneficiaries with affordable choices in health plan options, similar to the kinds of options available to FEHB Program enrollees. Providing reliable, high-quality plan participation requires not only creation of new alternatives, but also constructive changes to the processes and requirements previously imposed under the MA program (when it was called the Medicare+Choice (M+C) program. In the past, the way the program operated was seen as unnecessarily burdensome and a deterrent to participation by some health plans. This resulted in fewer plans participating and subsequently limited access to affordable coordinated-care plans for some beneficiaries. The program also was designed originally around an HMO model that does not work well for preferred provider organization (PPO) and HMO point of service (POS) plans.

The table below shows some of the important similarities between a newly reformed Medicare Advantage program and the FEHB Program. Medicare Advantage will become a competitive, consumer-driven system that enables beneficiaries to join the plans best suited to their needs.

Program Characteristics	FEHB Program	Medicare Advantage	Comment
Annual Open Season to choose plan	Yes	Yes	Focuses enrollees on their opportunity for choice
Multiple plans available in all areas of the country	Yes	Expected	Previously one third of beneficiaries have had no M+C coordinated care plan available; new MA regional and local plans should eliminate this gap
Plans compete based on premium, benefits, service, and provider networks	Yes	Yes	Competition pressures plans to improve benefits and performance
Plans have hospital, doctor, drug benefits	Yes	Yes	Previously, many M+C plans offered only minimal, or no, drug benefits
Plans have flexibility to design own options – no “one-size-fits all” single plan design	Yes	Yes	Although plan flexibility is expanded, MA core benefits must equal those of original Medicare
Information available comparing plan quality and benefits	Yes	Yes	Enables enrollees to make informed choices.
Emphasis on quality improvement	Yes	Yes	Plans focus on identifying real problems and developing solutions
Minimum red tape and barriers to flexibility	Yes	Yes	Numerous reductions in regulatory burden under MA, moving closer to the FEHB Program model
Multiple plan types allowed (HMO, PPO, POS, MSA)	Yes	Yes	MA encourages participation of new plan types
Plans "at risk" for profits or losses	Yes	Yes	Most FEHB Program enrollment is in "experience rated" plans that can recover some losses, but bear some risk; Cost plans phased out under MA
Detailed risk adjustment mechanism to mitigate adverse selection	No	Yes	Creates level playing field for plan competition

RECENTLY COMPLETED BURDEN REDUCTION INITIATIVES

CMS has already undertaken a series of initiatives to reduce the unnecessary administrative burden faced by health plans in their participation in the new MA program. These reforms help Medicare work more efficiently, without compromising and in many cases enhancing the beneficiary protections that Medicare provides. CMS has worked collaboratively with health plans and other stakeholders to help ensure smooth implementation of these improvements by:

-Automating the rate submission and review process to make it simpler and more efficient for plans to submit their proposals each year.

-Streamlining the application process for new and renewing MA plans.

-Allowing plans that reliably provide appropriate marketing materials to use these marketing materials under certain circumstances without waiting 45 days for CMS review. Instead, materials can be used 5 days after submission to CMS. This "file and use" system is similar to the FEHBP approach, where information is presumed to be accurate and intervention occurs when plans do not reliably provide accurate information.

-Developing and implementing an outcomes-focused performance review system. This also parallels the FEHBP practice.

-Reducing reporting, paperwork, and record-keeping requirements in a number of ways, including:

- Developing and implementing a reformed risk adjustment data collection system that minimizes burden on plans.
- Modifying provider re-credentialing requirements to every three years (rather than every two years) – which is comparable to standard, non-governmental industry practices.
- Reducing reporting of physician incentive program data by plans.
- Eliminating the imposition of new, mid-year requirements, which were neither known nor built into rates when they were submitted to CMS.
- Using an outside contract to manage the retroactive payment adjustment requests submitted by health plans, thereby significantly increasing the accuracy, consistency and timeliness of processing.

-Encouraging waivers that allow health plans and employers/unions to establish plans for use by the employer's retirees.

PLANNED REFORMS TO PROVIDE TAILORED ASSISTANCE TO MEDICARE BENEFICIARIES AND REDUCE BURDENS ON PLANS

The Medicare Advantage rule is based, in large part, on the MA program platform. The improvements and efficiencies recently achieved in that program are carried over into these rules. In addition, additional initiatives that tailor information and benefits for specific beneficiaries and reduce burden or reform procedures are implemented in the final Medicare Advantage rules. These include:

-Further reducing unnecessary paperwork by:

- Eliminating requirements that each Medicare Advantage organization provide information on competing plans that duplicates information already provided to beneficiaries by CMS. This reform reflects the substantial expansion of information dissemination by CMS in recent years in order to improve the availability of consistent, useful information. The innovations include a

plan comparison tool on the www.medicare.gov web site and the toll-free 1-800-MEDICARE phone line, as well as information in the *Medicare & You* handbook. In this way, we are able to give each beneficiary personalized information about the options in his or her area and assistance in making the right choice while, at the same time, removing an unnecessary plan burden.

- Eliminating requirements that practitioners provide unnecessary notices to enrollees at each encounter regarding any decision to deny services. We have also eliminated the requirement for a written notice when a favorable determination has been made orally. Both of these will eliminate confusing notices for beneficiaries while reducing plan burden.

-Targeting our new access to care requirements to deal with the special problems that will be faced by regional Medicare Advantage plans, and giving plans flexibility in how they will meet network requirements (e.g., by holding enrollees financially harmless if they need to use a non-network provider).

-Taking advantage of modern technology to help plans in program administration by:

- Making it easier for beneficiaries to enroll in Medicare Advantage plans by allowing additional mechanisms (other than paper) for enrollment applications that take advantage of modern technology for an efficient and simplified process for all parties.

- Providing organizations with more options (i.e., beyond traditional mailings) in how they notify enrollees of important changes as a way to ensure that beneficiaries get this information as quickly as possible.

- Making plan information more easily available for beneficiaries by encouraging plans to use up-to-date and easily searchable Web sites to provide important information such as provider lists and drug formularies. Almost all FEHB Program plans use Web sites to provide such information to enrollees.

-Allowing Medicare Advantage organizations more flexibility in responding to problems:

- Allowing plans to submit requests to restrict enrollment when capacity issues arise, rather than prior to the beginning of a contract year.

- Providing flexibility to plans in developing rules related to disenrolling individuals who fail to pay premiums. Proper notice and demonstrated reasonable efforts to collect premiums continue to apply to protect beneficiaries.

- Mitigating requirements regarding information organizations provide to enrollees about participating providers. Medicare Advantage organizations must only provide information on contracting providers that a beneficiary may "reasonably be expected" to use, such as providers in the area, rather than our current standard that requires disclosure of all contracting providers, wherever located. Of course, plans must still provide information to beneficiaries on providers outside their service area upon request.

-Refocusing "Quality Assurance" to "Quality Improvement" – to emphasize the organic and ongoing nature of the process of getting the best possible care for beneficiaries. Various reforms consistent with a "quality improvement" approach to quality standards are made to encourage plans to focus on

real problems as identified by the plans rather than on ritualistic documentation. This will improve care for Medicare Advantage enrollees as plans focus their improvement efforts on the health needs of their actual enrollees.

-Tailoring all substantive and administrative requirements to the unique characteristics of each type of plan. PPOs will not have to meet all HMO requirements, and Private FFS and MSA plans will not have to meet requirements appropriate only to coordinated care plans.

-Finding additional flexibilities in the use of waivers to facilitate employer/union participation and to accommodate unique situations involving an employer's retirees. Under the new rules, Medicare will be able to contract directly with employers or unions to provide care for their retirees. In this way, these individuals won't have to change plans just because they become Medicare-eligible – they can have seamless coverage as they transition to Medicare.

-Providing employers the ability to choose which payment frequency they prefer for the retiree drug subsidy—monthly, quarterly, or annually.

-Providing great flexibility to Special Needs Plans in tailoring their enrollment priorities and targeting their services.

-For each type of plan, providing for a liberal use of waivers to facilitate plan (and employer) participation and maximize tailoring of benefits to enrollee needs.